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7
8 **IN THE UNITED STATES DISTRICT COURT**
9 **FOR THE CENTRAL DISTRICT OF CALIFORNIA**

10 **LACV18 08311-PA-ASx**

CASE NO.

11 **[UNDER SEAL],**

12 Plaintiffs,

13 v.

14 **[UNDER SEAL],**

15 Defendant.

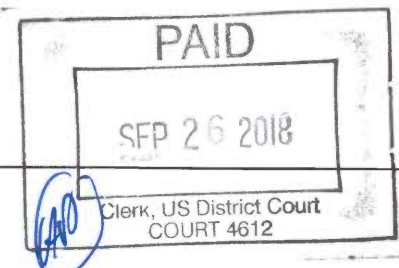
16 **COMPLAINT FOR MONEY**
17 **DAMAGES AND CIVIL PENALTIES**
18 **FOR:**

- 19 1. Violations of the Federal False
20 Claims Act, §§ 3729(a)(1)(a) and
21 (a)(1)(b);
22 2. Violations of the California False
23 Claims Act, Cal. Gov. Code
24 §12652; and
25 3. Violations of the California
26 Insurance Frauds Prevention
27 Act, Cal. Ins. Code §1871.7

28 **DEMAND FOR JURY TRIAL**

**[FILED IN CAMERA AND UNDER SEAL
PURSUANT TO 31 U.S.C. § 3730(b)(2)]**

COMPLAINT



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9 **FOR THE CENTRAL DISTRICT OF CALIFORNIA**
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11 **UNITED STATES OF AMERICA** *ex*
12 *rel.* **IONM LLC**, a Delaware corporation;
13 **STATE OF CALIFORNIA** *ex rel.*
14 **IONM LLC**, a Delaware corporation; and
LOS ANGELES COUNTY *ex rel.*
IONM LLC, a Delaware corporation;

15 Plaintiffs,

16 v.

17 **UNIVERSITY OF SOUTHERN**
18 **CALIFORNIA**, a California corporation

19 Defendant.
20
21
22
23

CASE NO.

**COMPLAINT FOR MONEY
DAMAGES AND CIVIL PENALTIES
FOR:**

1. Violations of the Federal False Claims Act, §§ 3729(a)(1)(a) and (a)(1)(b);
2. Violations of the California False Claims Act, Cal. Gov. Code §12652; and
3. Violations of the California Insurance Frauds Prevention Act, Cal. Ins. Code §1871.7

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1 Plaintiffs the United States of America ("United States"), State of California,
 2 and Los Angeles County, by and through Relator IONM, LLC (hereinafter, "Relator")
 3 allege as follows:

4 **I. INTRODUCTION**

5 1. Relator brings this action on behalf of the United States, the State of
 6 California, and Los Angeles County, to recover losses sustained as a result of
 7 fraudulent practices arising out of the Intraoperative Neurophysiological Monitoring
 8 ("IONM") Division under the Department of Neurology at the Keck School of
 9 Medicine at the University of Southern California.

10 2. Defendant UNIVERSITY OF SOUTHERN CALIFORNIA ("USC") is a
 11 California corporation based in Los Angeles. USC is the owner of the Keck School of
 12 Medicine and the Keck Medical Center which operates the Keck Hospital of USC. The
 13 USC Department of Neurology operates under the Keck School of Medicine.

14 3. IONM attempts to minimize neurological morbidity during high-risk
 15 neurosurgical, orthopedic, peripheral nerve, cardiothoracic, ear, nose and throat
 16 ("ENT"), and vascular surgeries.

17 4. Defendant has perpetrated a fraud on the taxpayers and private insurance
 18 companies by falsifying records and billing for IONM services not provided. The
 19 fraud occurs in connection with services at both USC Keck Hospital and at the Los
 20 Angeles County Medical Center (now known as, and hereinafter referred to as
 21 "LAC+USC Medical Center," or "LAC+USC"), at which USC provides IONM
 22 services pursuant to negotiated annual contract.

23 5. Defendant's fraud takes several forms. For example, Defendant billed for
 24 IONM services simply not performed. To seek reimbursement for IONM professional
 25 oversight, a physician must continuously monitor the procedure in real time,
 26 communicate analysis of the data to the surgical team, and document the IONM
 27 physician's involvement in the patient's medical record. At both USC Keck and
 28 LAC+USC, Defendant systematically failed to meet these basic requirements of IONM

1 oversight. Defendant placed thousands of patients at risk by failing to provide
2 continuous oversight of surgical cases, instructed the permanent deletion of chat logs
3 from the patients' medical records to hide the lack of communication between
4 physician and technologist, and attempted to avoid liability by not signing procedure
5 notes in the patients' medical records.

6 6. In another example of persistent fraud, Defendant billed for IONM
7 services not rendered for nearly all the ENT surgeries performed at both USC Keck
8 and LAC+USC. The IONM machine used to perform most of the monitoring of ENT
9 surgeries at USC Keck and LAC+USC requires that analysis of the IONM data be
10 performed in-person, in the operating room. The machine cannot transmit streaming
11 data to locations outside of the operating room, and therefore remote monitoring is not
12 possible. Despite this, Defendant repeatedly billed third-party payers for professional
13 oversight of ENT surgeries at both USC Keck and LAC+USC using incorrect CPT
14 codes. This is not a case of simple error; real-time physician monitoring was occurring
15 neither remotely nor in-person, putting patients at significant risk of neurologic injury
16 during these critical surgeries. In addition, Defendant also billed for physician
17 oversight of ENT surgeries using in-room CPT codes when no IONM physician was
18 actually present in the operating room for the duration of time billed.

19 7. Additionally, USC has repeatedly engaged in systematic billing
20 manipulation by upcoding charges to maximize insurance reimbursement.
21 Specifically, because reimbursement rates for "in-room" monitoring are typically
22 higher than for "remote" monitoring, USC often bills for units of "in-room"
23 monitoring when monitoring occurred remotely or not at all, or falsely inflates the
24 amount of "in-room" monitoring time in order to maximize reimbursement.

25 8. In addition, USC has routinely falsified records and billed under the
26 provider numbers of physicians who did not actually provide the oversight. This
27 fraudulent "switching" of providers was done in order to avoid certain billing rules and
28 maximize insurance reimbursement. In particular, some commercial insurers allow

1 physicians to bill for the time spent monitoring multiple surgeries simultaneously. In
 2 contrast, Medicare, United Health Care, Worker's Compensation carriers, and
 3 Medicare Advantage plans restrict physician reimbursement of time monitored to one
 4 surgery at any given moment, even if the physician is providing oversight to multiple
 5 surgeries simultaneously. To evade these rules, USC routinely switches the names of
 6 the monitoring physicians in a fraudulent scheme to misrepresent the provider of
 7 service.

8 9. This egregious fraud has significant real-life consequences for patients, as
 9 evidenced by thousands of surgeries where patients' lives were put at risk. The core
 10 purpose of IONM monitoring is to identify changes in signals generated by the patient
 11 that could reflect stress or impact to the neurological systems of patients during
 12 surgery. When such signals are detected by physicians, the operating surgeons are
 13 immediately notified so that they can modify the course of the surgery to avoid
 14 damage to the nervous system. Without *real-time, continuous* monitoring and analysis
 15 by qualified physicians, the IONM services are essentially worthless. USC is
 16 reimbursed generously for IONM services that are supposed to be performed by highly
 17 trained physician specialists; not by IONM technologists who lack the credentials to
 18 make such critical clinical decisions. These fraudulent schemes have put the health
 19 and welfare of thousands of patients at risk.

20 10. USC's actions have resulted in numerous violations of the Federal False
 21 Claims Act, the California False Claims Act, and California Insurance Code Section
 22 1871.7. This is a *qui tam* action to recover treble damages, civil penalties, attorneys'
 23 fees, and costs for Relator on behalf of both the United States and the State of
 24 California.

25 11. The Relator, through deep investigation and inside knowledge of
 26 Defendant's operations, has obtained non-public, direct evidence supporting the
 27 allegations in this Complaint. Among other evidence, Relator has obtained and/or
 28 compiled based on first-hand information records of medical billing, scheduling,

1 financial records, and other evidence that show the submission of fraudulent medical
2 billing that underlie the scheme at issue.

3 **II. JURISDICTION AND VENUE**

4 12. This Court has jurisdiction over the False Claims Act ("FCA") causes of
5 action raised in this complaint under 28 U.S.C. § 1331, as they arise under Federal law.
6 This Court also has jurisdiction over the FCA claims pursuant to 31 U.S.C. § 3732,
7 which confers jurisdiction for claims brought under the FCA on the District Courts of
8 the United States.

9 13. Additionally, this Court has supplemental jurisdiction over the other
10 claims in this action pursuant to 31 U.S. Code § 3732(b), as they arise from the same
11 transaction or occurrence as the federal claims. The Court also has supplemental
12 jurisdiction pursuant to 28 U.S.C. § 1367, as they are so related to the FCA claims in
13 the action that they form part of the same case or controversy.

14 14. Venue is proper pursuant to 31 U.S.C. § 3732(a), as Defendant transacts
15 business in this District, and the fraudulent conduct was committed here.

16 **III. PARTIES**

17 **A. Relator**

18 15. Plaintiffs in this action are the United States of America, State of
19 California, and Los Angeles County, by and through Relator IONM LLC.

20 16. Relator's members have direct and independent knowledge of the
21 information on which these allegations are based. Its members have access to financial
22 information, provider records, patient notes, and other documentation of the
23 Defendant's ongoing scheme.

24 17. The facts alleged in this Complaint are based entirely upon Relator's
25 members' personal observations and investigation, as well as documents in their
26 possession.

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28 ///

1 **B. Defendant**

2 18. Defendant USC, through the Keck School of Medicine, provides medical
3 education, training and clinical services, throughout numerous departments, serving
4 the Los Angeles area. The Keck School of Medicine is part of Keck Medicine of USC,
5 the University of Southern California's medical enterprise and one of two university-
6 owned academic medical centers in the Los Angeles area.

7 19. In addition to Defendant's onsite clinical services at the USC hospital,
8 Defendant also offers services at LAC+USC through the Los Angeles County
9 Department of Public Health's Medical School Operating Agreement ("MSOA") fund
10 and/or Medical School Affiliation Agreement ("MSAA"), and/or Professional Services
11 Agreement ("PSA") contracts that are negotiated annually. Under the MSOA and/or
12 MSAA and/or PSA, Los Angeles County pays USC several hundred thousand dollars
13 per year to perform both the professional and technical IONM services for surgeries
14 conducted at LAC+USC and covered by a variety of payers—including Medi-Cal,
15 Medicare, and private insurers.

16 **IV. OVERVIEW OF THE SCHEME**

17 **A. Statutory Background**

18 **1. Federal False Claims Act**

19 20. The Federal False Claims Act ("FCA"), as amended by the Fraud
20 Enforcement and Recovery Act of 2009 ("FERA"), Pub. L. 111-21, section 4(f), 123
21 Stat. 1617, 1625 (2009), provides in pertinent part that a person is liable to the United
22 States government for three times the amount of damages the government sustains
23 because of the act of that person, plus a civil penalty, for each instance in which the
24 person "knowingly presents, or causes to be presented, a false or fraudulent claim for
25 payment or approval." 31 U.S.C. § 3729(1)(1)(A) (2009).

26 21. The FCA defines the term "claim" to mean "any request or demand,
27 whether under a contract or otherwise, for money or property and whether or not the
28 United States has title to the money or property, that (i) is presented to an officer,

1 employee, or agent of the United States; or (ii) is made to a contractor, grantee, or
2 other recipient, if the money or property is to be drawn down or used on the
3 Government's behalf or to advance a Government program or interest, and if the
4 United States Government (i) provides or has provided any portion of the money or
5 property requested or demanded; or (ii) will reimburse such contractor, grantee, or
6 other recipient for any portion of the money or property which is requested or
7 demanded." 31 U.S.C. § 3729(b)(2)(A) (2009).

8 22. As amended by FERA, the FCA also makes a person liable to the United
9 States government for three times the amount of damages which the government
10 sustains because of the act of that person, plus a civil penalty, for each instance in
11 which the person "knowingly makes, uses, or causes to be made or used, a false record
12 or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B)
13 (2009).

14 23. The FCA defines the terms "knowing" and "knowingly" to mean that a
15 person, with respect to information: (1) "has actual knowledge of the information"; (2)
16 "acts in deliberate ignorance of the truth or falsity of the information"; or (3) "acts in
17 reckless disregard of the truth or falsity of the information." 31 U.S.C. §
18 3729(b)(1)(A) (2009). The FCA further provides that "no proof of specific intent to
19 defraud" is required. 31 U.S.C. § 3729(b) (2006); 31 U.S.C. § 3729(b)(1)(B) (2009).

20 24. On behalf of the United States of America, Relator alleges that over the
21 course of the past decade, Defendant has violated the FCA by "knowingly" submitting
22 false claims for payment to Medicare. In addition, through Defendant's contract for
23 services with the County of Los Angeles, Defendant "knowingly" caused submission
24 of false claims to Medicare by the County of Los Angeles. Relator alleges, during this
25 same time period, that Defendant knowingly concealed and/or knowingly and
26 improperly avoided an obligation to pay or transmit money to the U.S. government by
27 obtaining reimbursement related to their submissions of false claims for payment to
28 Medicare. This conduct is ongoing.

2. The California False Claims Act

25. The California False Claims Act (“CFCA”) provides in pertinent part that a person is liable to the State of California for three times the amount of damages the government sustains because of the act of that person, plus a civil penalty, for each instance in which the person “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” Cal. Gov. Code § 12651(a)(1).

26. The California False Claims Act defines the term “claim” to mean “any request or demand, whether under a contract or otherwise, for money, property, or services, and whether or not the state or a political subdivision has title to the money, property, or services that meets either of the following conditions: (A) is presented to an officer, employee, or agent of the state or of a political subdivision; (B) is made to a contractor, grantee, or other recipient, if the money, property, or service is to be spent or used on a state or any political subdivision's behalf or to advance a state or political subdivision's program or interest, and if the state or political subdivision meets either of the following conditions (i) provides or has provided any portion of the money, property, or service requested or demanded; or (ii) reimburses the contractor, grantee, or other recipient for any portion of the money, property, or service which is requested or demanded.” Cal. Gov. Code § 12651(b)(1).

27. On behalf of the State of California, Relator alleges that over the course of the past decade, Defendant violated the California False Claims Act by “knowingly” submitting false claims for payment to Medi-Cal. In addition, through Defendant’s contract for services with the County of Los Angeles, Defendant “knowingly” caused submission of false claims to Medi-Cal by the County of Los Angeles.

28. Moreover, Defendant has knowingly violated the CFCA by defrauding Los Angeles County—a political subdivision of California. As described herein, Defendant has fraudulently induced the County to enter into the MSOA and/or MSAA and/or PSA contracts pursuant to which USC is supposed to provide IONM services at LAC+USC, and has failed to provide those services in violation of the contracts.

1 29. The conduct described herein is ongoing.

2 **3. California Insurance Frauds Prevention Act**

3 30. The California Insurance Frauds Prevention Act ("CIFPA") provides that
4 any person or entity who knowingly submits, or causes the submission of, a false or
5 fraudulent claim to a private insurer in California for payment or approval is liable for
6 a civil penalty of up to \$10,000 for each such claim, plus three times the amount of the
7 damages sustained by the insurer. Cal. Ins. Code § 1871.7(b). The Court may also
8 grant equitable relief to protect the public.

9 31. The CIFPA empowers and encourages any interested person to bring a
10 civil action under Ins. Code § 1871.7 against those who submit, or cause to be
11 submitted, false or fraudulent claims against insurers.

12 32. A complaint brought pursuant to § 1871.7 is required to be filed in camera
13 and under seal for sixty (60) days to allow the government to conduct its own
14 investigation without the knowledge of Defendant, and to determine whether to join in
15 the suit. Further, a copy of the complaint and written disclosure of substantially all
16 material evidence shall be served on the District Attorney of the county in which the
17 matter is filed and Insurance Commissioner of the State of California. Relator has
18 complied with these requirements. Simultaneously with the filing of the Complaint in
19 this action, Relator provided written disclosure of substantially all material evidence
20 regarding the allegations contained in the Complaint to the Los Angeles District
21 Attorney's Office and to the office of the Insurance Commissioner of the State of
22 California. Relator also offered complete cooperation in any potential investigation
23 initiated by the above-referenced government entities.

24 33. Relator is an original source for all of the information contained in this
25 Complaint as defined by California Insurance Code section 1871.7. Relator has direct
26 and independent knowledge of the information on which the allegations contained
27 herein are based, and has voluntarily provided this information to the District Attorney
28 and Commissioner before filing the present action.

1 34. Relator alleges that over the course of the past decade, Defendant has
2 violated the CIFPA by “knowingly” submitting false claims to private insurers in
3 California. Additionally, Defendant “knowingly” caused false claims to be submitted
4 to private insurers through its work with the County of Los Angeles.

5 35. Based on the foregoing laws, Relator seeks, through this action, to recover
6 damages and civil penalties arising from the false or fraudulent records, statements
7 and/or claims that Defendant knowingly made or caused to be made in connection with
8 their fraudulent scheme.

9 36. The conduct described herein is ongoing.

10 **B. IONM Billing Background and Defendant’s Fraudulent Scheme**

11 **1. Intraoperative Neurophysiologic Monitoring (IONM)**

12 37. IONM is a sub-specialty of neurology and utilized to minimize
13 neurological morbidity during- neurosurgical, orthopedic, peripheral nerve,
14 cardiothoracic, ENT, and vascular surgeries where the nervous system is at risk. The
15 goal of such monitoring is to identify changes in brain, spinal cord, and peripheral
16 nerve function prior to irreversible damage. IONM monitoring by the oversight
17 physician can take place either in the operating room or remotely. At USC Keck and
18 LAC+USC, most monitoring is performed when the IONM physician is outside of the
19 operating room.

20 38. Standard of care in the industry requires a continuously open, bilateral
21 communication channel between the IONM physician and the IONM technologist who
22 is present in the operating room. This is typically a typewritten live chat, run through
23 an IONM software program. These “Chat Logs” thus document which physician
24 monitored the surgery, and reflect the physician’s interpretation and communication of
25 both baseline signals and subsequent data acquired throughout the entire course of the
26 surgery. After the physician conveys analysis of the data to the technologist via the
27 Chat Log, the technologist then relays this information to the surgeon and documents it
28 in a separate “Event Log” that is part of the IONM data file.

1 39. IONM technologists are not licensed or permitted to exercise independent
2 clinical judgment or provide feedback relating to analysis of the data to the surgeons
3 without physician input.

4 40. Standard of care requires that the IONM physician continually monitor
5 the surgery at all times and relay interpretation of the incoming real-time data, even
6 when no significant changes in the neurophysiological signals have occurred. The
7 IONM physician must be licensed in the state and privileged at the specific hospital
8 where the surgery is being performed in order to provide intraoperative
9 neurophysiologic monitoring oversight. As the Current Procedural Terminology codes
10 (“CPT” codes) indicate per Defendant’s training materials, the IONM physician is
11 responsible for real-time interpretation of data and is responsible for continually
12 assessing the data and communicating the assessment to the technologist, who
13 subsequently communicates this to the surgeon. (See Exhibit 1.) Both physician
14 interpretation of the data and communication of that analysis between physician and
15 technologist must be explicitly documented. A lack of communication does not imply
16 implicit communication. As Defendant’s own training materials state, “provisions”
17 must be in place for “continuous and immediate communication.” (See Exhibit 1.) As
18 described above, this communication should be documented through “Chat Logs”
19 between the technologist and IONM physician.

20 41. IONM fellowship training is available at some academic institutions.
21 IONM fellowships are non-accredited and are not governed by the Accreditation
22 Council for Graduate Medical Education (ACGME). These trainees are often
23 neurologists who seek subspecialized training in the field of IONM. During
24 fellowship, trainees are taught by established IONM physicians who teach the fellows
25 how to appropriately monitor IONM cases. The training program also usually
26 encourages the fellow to perform research in the field. After completing an IONM
27 fellowship, the graduate may be eligible to seek subspecialty board certification.

28 ///

1 **2. Ear, Nose and Throat (ENT) Surgeries Require In-Person**
 2 **Monitoring**

3 42. Ear, Nose and Throat (“ENT”) surgeries at USC Keck and LAC+USC
 4 often utilize a specific type of monitoring equipment called the “NIM” machine. The
 5 manufacturer of the NIM machine, Medtronic, provides detailed specifications for its
 6 equipment confirming that it cannot send real-time streaming data through the internet
 7 to a remote location. Chat logs and electronic event logs are not available with the
 8 NIM machine. Nor does the NIM machine generate a data file for retrospective
 9 analysis. Therefore, any surgery monitored using the NIM machine requires the
 10 IONM physician to be physically present in the operating room throughout the entire
 11 duration of the surgery in order to provide appropriate patient care in real-time.
 12 Because physician oversight can only be performed in in the operating room, CPT
 13 codes specific to remote monitoring cannot be used.

14 **3. Current Procedural Terminology (“CPT”) Codes and**
 15 **Reimbursement Guidelines**

16 43. Current Procedural Terminology codes (“CPT” codes) recognized by
 17 insurers for IONM services include G0453, 95940, and 95941. These CPT codes
 18 allow the oversight physician to bill for time monitored (also known as the “time
 19 component”). Prior to 2013, the CPT code used for billing time monitored was CPT
 20 95920.

21 44. In addition to billing for time monitored, the oversight physician may also
 22 bill for the modalities monitored, often referred to as the “base codes”. These codes
 23 include but are not limited to somatosensory evoked potentials (SEPs), motor evoked
 24 potentials (MEPs), electromyography (EMG), and electroencephalography (EEG).

25 45. Under any of these codes, the IONM physician must continuously
 26 monitor the surgery in order to bill insurance the professional fees. If continuous
 27 monitoring is not provided, neither the time component nor the base codes should be
 28 billed because appropriate oversight was not given.

1 46. CPT Code 95940 is specified for continuous IONM in the operating
 2 room, which is one-on-one monitoring requiring personal attendance. Each unit of
 3 CPT code 95940 represents 15 minutes of monitoring time, rounded to the nearest 15
 4 minute interval. All insurers accept the “in-room” CPT code 95940.

5 47. CPT Code 95941 is specified for continuous IONM from outside the
 6 operating room, remote or nearby, or for monitoring of more than one surgery while in
 7 the operating room. Each unit of CPT 95941 represents one hour of monitoring time,
 8 rounded to the nearest hour. Medi-Cal and commercial insurers (other than United
 9 Healthcare) accept CPT 95941.

10 48. HCPCS Code G0453 is specified for continuous IONM from outside the
 11 operating room, remote or nearby. Each unit of G0453 represents 15 minutes of
 12 monitoring time, rounded to the nearest 15 minute interval. The insurers who require
 13 usage of G0453 include Medicare, United Healthcare, Worker’s Compensation, and
 14 Senior HMOs.

15 49. Medicare developed CPT Code G0453 to be used in place of CPT 95941
 16 because it does not pay the professional time component for multiple *simultaneous*
 17 monitoring surgeries—which is allowed under CPT 95941. United Healthcare,
 18 Worker’s Compensation carriers, and Senior HMO’s have since followed Medicare’s
 19 rule in this regard.

20 50. Notably, all three of these CPT codes require *continuous* monitoring of
 21 the IONM signals by qualified physicians. USC’s own internal training materials
 22 emphasize this point, stating, in pertinent part:

23 “CPT introductory language and AMA coding guidance is clear that in
 24 order to bill these codes (+95940, +95941, or G0453) the service must be
 25 performed by a monitoring professional who is **SOLELY DEDICATED**
 to performing the intraoperative neurophysiologic monitoring and is
 available to intervene at all times during the service as necessary.”

26 (Exhibit 2, at 14. Emphasis in original.)

27 ///

28 ///

1 51. As described above, along with each monitoring code, the physician
 2 typically also bills “base” codes that describes the particular modalities being
 3 monitored. Examples of common base codes include somatosensory evoked potentials
 4 or SEP (CPT 95938), motor evoked potentials or MEP (CPT 95939),
 5 electroencephalography or EEG (CPT 95822), and EMG (CPT 95861). Because
 6 professional oversight was not performed continuously, Defendant should not have
 7 submitted claims for such base codes. In other words, for every false monitoring code
 8 billed, Defendant typically submitted false base code charges as well.

9 52. In most instances, USC also charged payers for the work provided by the
 10 technologist under the “technical component” of base codes or monitoring codes.
 11 Because Defendant failed to provide professional IONM oversight, Defendant’s claims
 12 for the technical component were false and fraudulent. Because the IONM procedure
 13 was not performed as required by standard of care, all payments including monies paid
 14 for technologists and oversight physicians were false and fraudulent.

15 53. Prior to 2013, the only CPT code designed for IONM monitoring (on top
 16 of the base codes) was 95920. CPT 95920 could be used for in-room or remote
 17 monitoring, and each unit represented one hour of monitoring. Under CPT 95920,
 18 Medicare only allowed remote monitoring of one surgery at a time.

19 **4. Evidence of Defendant’s Fraudulent Conduct**

20 54. Over the course of the past decade, Defendant has perpetrated a fraud on
 21 taxpayers and insurance companies by falsifying medical records, billing and receiving
 22 monies for IONM services not rendered, and falsifying documents to misrepresent
 23 time spent performing purported patient care at USC Keck and LAC+USC Medical
 24 Center in order to receive inflated funding. The fraudulent schemes described in this
 25 complaint have occurred at the direction of, or with the knowledge of, high ranking
 26 members of the USC Keck Division of Neurology, including: Helena Chang Chui,
 27 M.D. (“Dr. Chui”), the Chair of Neurology, Andres Gonzalez, M.D. (“Dr. Gonzalez”),
 28 IONM Division Chief, and Parastou Shilian, D.O. (“Dr. Shilian”), Senior Attending. It

1 is likely that Drs. Gonzalez and Chui have perpetrated these frauds since 2006, and Dr.
 2 Shilian since 2011. Dr. Chui is Professor and Chair of Neurology at Defendant's Keck
 3 School of Medicine. She leads the entire Department of Neurology including the
 4 IONM physicians and LAC-USC technologists, manages the Department's budget and
 5 negotiates the annual MSOA and/or MSAA and/or PSA funding from LAC+USC. Dr.
 6 Gonzalez is an Assistant Professor of Neurology and the IONM Division Chief who
 7 directs the Surgical Neurophysiology Program at Defendant's Keck Hospital of USC
 8 and the L.A. County-USC Medical Center. Dr. Shilian is an Assistant Professor of
 9 Neurology and Senior Attending for the IONM Division, at Defendant's Keck School
 10 of Medicine. Drs. Gonzalez and Shilian provide IONM clinical services based on a set
 11 weekly schedule, distributed by Dr. Chui, under which only one attending physician is
 12 "in charge" of clinical decisions on a given day. As detailed below, despite this set
 13 schedule, in order to maximize reimbursement, USC instituted a "group billing"
 14 scheme pursuant to which it bills payers under the names of physicians who did not
 15 perform the service.

16 55. Defendant repeatedly fraudulently billed Medicare, Medi-Cal, and private
 17 insurers for IONM oversight at both USC Keck and LAC+USC by, among other
 18 things, billing for services not provided, upcoding, and falsifying/switching the names
 19 of the monitoring physician to maximize reimbursement. The following cases provide
 20 examples of the multiple fraudulent and false aspects of USC's procedures at both
 21 USC Keck and LAC+USC hospitals.

22 i. **Fraudulent billing for "In-Room" monitoring when**
 23 **monitoring was performed remotely or not at all**

24 56. Patient DF, a 65-year-old, underwent surgery at LAC+USC on August 15,
 25 2017. USC provided IONM services for the surgery. USC falsely certified that it
 26 provided eight units of in-room "Continuous IONM" under CPT code 95940. USC
 27 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
 28 other USC IONM monitoring physician, was present in the operating room during the

1 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
2 exits to the operating room. (See Exhibit 3.) USC's internal billing records for the
3 surgery are attached hereto as Exhibit 4. Patient DF was insured by Los Angeles
4 County's In-Home Support Services program, which is funded through a mix of local,
5 state, and federal taxpayer dollars. As indicated in the surgical notes, during the
6 procedure, there was a critical change in IONM signals which prompted the
7 neurosurgeon to perform an urgent and unplanned, additional surgical procedure. At
8 the end of the entire surgery, IONM signals were still significantly reduced. (See
9 Exhibit 3.) The IONM note was signed only by the technologist, not Dr. Gonzalez or
10 any other monitoring physician, thereby reflecting and confirming that necessary
11 oversight was not provided. This failure directly violates standard medical practice
12 and various payer requirements.

13 57. Patient MG, a 61-year-old, underwent surgery at LAC+USC on March 2,
14 2018. USC provided IONM services for the surgery. USC falsely certified that it
15 provided seven units of in-room "Continuous IONM" under CPT code 95940. USC
16 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
17 other USC IONM monitoring physician, was present in the operating room during the
18 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
19 exits to the operating room. Patient MG was insured by Medi-Cal. The IONM note
20 was signed only by the technologist, not Dr. Gonzalez or any other monitoring
21 physician, thereby reflecting and confirming that necessary oversight was not
22 provided. This failure directly violates standard medical practice and various payer
23 requirements.

24 58. Patient QTH, a 62-year-old, underwent surgery at LAC+USC on March 2,
25 2018. USC provided IONM services for the surgery. USC falsely certified that it
26 provided six units of in-room "Continuous IONM" under CPT code 95940. USC
27 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
28 other USC IONM monitoring physician, was present in the operating room during the

1 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
2 exits to the operating room. Patient QTH was insured by Los Angeles County's In-
3 Home Support Services program, which is funded through a mix of local, state, and
4 federal taxpayer dollars. The IONM note was signed only by the technologist, not Dr.
5 Gonzalez or any other monitoring physician, thereby reflecting and confirming that
6 necessary oversight was not provided. This failure directly violates standard medical
7 practice and various payer requirements.

8 59. Patient LL, a 32-year-old, underwent surgery at LAC+USC on June 5,
9 2015. USC provided IONM services for the surgery. USC falsely certified that it
10 provided in-room "Continuous IONM" under CPT code 95940. USC listed Dr.
11 Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any other
12 USC IONM monitoring physician, was present in the operating room during the
13 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
14 exits to the operating room. Patient LL was insured by Medi-Cal.

15 60. Patient HL, a 54-year-old, underwent surgery at LAC+USC on December
16 19, 2017. USC provided IONM services for the surgery. USC falsely certified that it
17 provided eight units of in-room "Continuous IONM" under CPT code 95940. USC
18 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
19 other USC IONM monitoring physician, was present in the operating room during the
20 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
21 exits to the operating room. Patient HL was insured by Medi-Cal. As indicated in the
22 surgical notes, there were neurological complications during the surgery. At the end of
23 the surgery, the patient was woken up in the operating room and demonstrated
24 complete loss of motor function on the right side of his body. The IONM note was
25 signed only by the technologist, not Dr. Gonzalez or any other monitoring physician,
26 thereby reflecting and confirming that necessary oversight was not provided. This
27 failure directly violates standard medical practice and various payer requirements.

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1 61. Patient MM, a 60-year-old, underwent surgery at LAC+USC on January
2 6, 2017. USC provided IONM services for the surgery. USC falsely certified that it
3 provided four units of in-room "Continuous IONM" under CPT code 95940. USC
4 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
5 other USC IONM monitoring physician, was present in the operating room during the
6 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
7 exits to the operating room. Patient MM was insured by Medi-Cal Managed Care. As
8 indicated in the surgical notes, there were neurological complications during the
9 surgery, and MM awoke the day after surgery with complete loss of motor function on
10 her left side. The IONM note was signed only by the technologist, not Dr. Gonzalez or
11 any other monitoring physician, thereby reflecting and confirming that necessary
12 oversight was not provided. This failure directly violates standard medical practice
13 and various payer requirements.

14 62. Patient KP, a 30-year-old, underwent surgery at LAC+USC on July 17,
15 2015. USC provided IONM services for the surgery. USC falsely certified that it
16 provided in-room "Continuous IONM" under CPT code 95940, which lasted six and a
17 half hours, according to the technologist's report. USC listed Dr. Gonzalez as the
18 monitoring physician. In fact, neither Dr. Gonzalez, nor any other USC IONM
19 monitoring physician, was present in the operating room during the surgery, as
20 evidenced by the final OR Intraoperative Record, which tracks all entries and exits to
21 the operating room. Patient KP was insured by Medi-Cal Managed Care. The IONM
22 note was signed only by the technologist, not Dr. Gonzalez or any other monitoring
23 physician, thereby reflecting and confirming that necessary oversight was not
24 provided. This failure directly violates standard medical practice and various payer
25 requirements.

26 63. Patient LSG, a 21-year-old, underwent surgery at LAC+USC on March
27 28, 2018. USC provided IONM services for the surgery. USC falsely certified that
28 Shilian provided in-room "Continuous IONM" under CPT code 95940, which lasted

1 three and a half hours before it was discontinued. USC listed Dr. Shilian as the
2 monitoring physician. In fact, neither Dr. Shilian, nor any other USC IONM
3 monitoring physician, was present in the operating room during the surgery, as
4 evidenced by the final OR Intraoperative Record, which tracks entries and exits to the
5 operating room. Patient LSG was insured by Medi-Cal. The IONM note was signed
6 only by the technologist, not Dr. Shilian or any other monitoring physician, thereby
7 reflecting and confirming that necessary oversight was not provided. This failure
8 directly violates standard medical practice and various payer requirements.

9 64. Patient ES, a 68-year-old, underwent surgery at LAC+USC on January
10 19, 2018. USC provided IONM services for the surgery. USC falsely certified that it
11 provided six units of in-room "Continuous IONM" under CPT code 95940. USC
12 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
13 other USC IONM monitoring physician, was present in the operating room during the
14 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
15 exits to the operating room. Patient ES was insured by Medicare. As indicated in the
16 surgical notes, there were neurological complications during the surgery, and ES lost
17 significant motor function in her upper right arm. The IONM note was signed only by
18 the technologist, not Dr. Gonzalez or any other monitoring physician, thereby
19 reflecting and confirming that necessary oversight was not provided. This failure
20 directly violates standard medical practice and various payer requirements.

21 65. Patient CS, a 51-year-old, underwent surgery at LAC+USC on March 2,
22 2018. USC provided IONM services for the surgery. USC falsely certified that it
23 provided six units of in-room "Continuous IONM" under CPT code 95940. USC
24 listed Dr. Gonzalez as the monitoring physician. In fact, neither Dr. Gonzalez, nor any
25 other USC IONM monitoring physician, was present in the operating room during the
26 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
27 exits to the operating room. Patient CS was insured by Medi-Cal Managed Care. The
28 IONM note was signed only by the technologist, not Dr. Gonzalez or any other

1 monitoring physician, thereby reflecting and confirming that necessary oversight was
2 not provided. This failure directly violates standard medical practice and various payer
3 requirements.

4 66. Patient MS, a 61-year-old, underwent surgery at LAC+USC on March 28,
5 2018. USC provided IONM services for the surgery. USC falsely certified that it
6 provided five units of in-room "Continuous IONM" under CPT code 95940. USC
7 listed Dr. Shilian as the monitoring physician. In fact, neither Dr. Shilian, nor any
8 other USC IONM monitoring physician, was present in the operating room during the
9 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
10 exits to the operating room. Patient CS was insured by Medi-Cal Managed Care. The
11 IONM note was signed only by the technologist, not Dr. Shilian or any other
12 monitoring physician, thereby reflecting and confirming that necessary oversight was
13 not provided. This failure directly violates standard medical practice and various payer
14 requirements.

15 67. Patient DV, a 38-year-old, underwent surgery at LAC+USC on July 7,
16 2016. USC provided IONM services for the surgery. USC falsely certified that it
17 provided five units of in-room "Continuous IONM" under CPT code 95940. USC
18 listed Dr. Shilian as the monitoring physician. In fact, neither Dr. Shilian, nor any
19 other USC IONM monitoring physician, was present in the operating room during the
20 surgery, as evidenced by the final OR Intraoperative Record, which tracks entries and
21 exits to the operating room. Patient DV was insured by Medi-Cal. The IONM note
22 was signed only by the technologist, not Dr. Shilian or any other monitoring physician,
23 thereby reflecting and confirming that necessary oversight was not provided. This
24 failure directly violates standard medical practice and various payer requirements.

25 68. As these examples show, USC's physicians did not provide continuous
26 oversight as required by standard of care, the MSOA and/or MSAA and/or PSA
27 contracts, and the CPT codes under which the services were billed. As to surgeries at
28 LAC+USC, this directly violated the MSOA and/or MSAA and/or PSA contracts

1 under which Los Angeles County was paying USC significant amounts of taxpayer
2 money, and also caused the County to submit false claims for payment to Medicare,
3 Medi-Cal, and private insurers.

4 69. Ironically, Drs. Gonzalez and Shilian did not sign IONM notes for the
5 LAC+USC surgeries that they were supposed to have monitored, presumably out of a
6 misguided fear of being held liable for harm suffered by patients during those surgeries
7 and being prosecuted for ordering technologists to submit fraudulent billing of “in-
8 room” physician services under the physicians’ provider numbers.

9 **ii. Upcoding at USC Keck by misrepresenting location of**
10 **physician monitoring as “In Room”**

11 70. At USC Keck, Defendant defrauded insurance by billing codes for “in
12 room” monitoring (CPT 95940) in combination with “remote” monitoring (CPT
13 95941) in the same surgery. Defendant repeatedly misrepresented location of service
14 to fraudulently obtain higher reimbursements and knowingly took advantage of the
15 significantly higher reimbursement rates that USC contracted with commercial insurers
16 for performing in-room IONM monitoring compared to remote IONM monitoring.

17 71. Patient TV was a 63 year-old woman who underwent spine surgery at
18 USC Keck on March 5, 2018. The total duration of intraoperative monitoring was 9
19 hours. Dr. Shilian billed the patient’s insurance, Blue Shield PPO, 9 units of CPT
20 95940 for in-room monitoring in addition to 7 units of CPT 95941 for remote
21 monitoring. The detailed operating room log from the surgery recorded 26 different
22 individuals who entered and exited the surgery including the 4 USC IONM
23 technologists who made 14 entries and exits. Despite the fact that Dr. Shilian charged
24 insurance for 9 units of in-room monitoring for this surgery, there is no documentation
25 of her presence in the operating room. (Exhibit 11).

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1 **iii. Fraudulent billing for ENT procedures where physician**
 2 **monitoring not provided**

3 72. As described above, in nearly all Ear, Nose and Throat (“ENT”) surgeries
 4 at both USC Keck and LAC+USC, IONM is performed using a machine (NIM) that
 5 does not allow for remote monitoring; the monitoring physician must be present in the
 6 operating room. USC nonetheless fraudulently billed for remote IONM monitoring for
 7 ENT surgeries performed at USC Keck and in person IONM monitoring for ENT
 8 surgeries performed at both USC Keck and LAC+USC despite the fact that OR records
 9 will show the physician was never in the operating room for these cases. Moreover, on
 10 cases at LAC+USC, for which USC was being paid directly through MSOA and/or
 11 MSAA and/or PSA funding to provide IONM services by technologists and
 12 physicians, USC did not provide physician oversight of ENT surgeries, in violation of
 13 the terms of its contract with LAC+USC and the standard of care.

14 73. For example, patient JQ underwent ENT surgery at LAC+USC on
 15 September 18, 2017. An IONM technologist was present, but USC provided no in-
 16 person or remote physician monitoring of the procedure. The technologist was an
 17 outside vendor hired by USC to perform IONM technologist services during this ENT
 18 surgery. During the surgery, the technologist provided interpretation of the NIM data
 19 to the surgical team without physician oversight which is not the standard of care.
 20 Thereafter, he sent an email to Defendant’s IONM administrative assistant citing
 21 concern that the lead USC IONM technologist informed him there is no professional
 22 oversight of ENT surgeries at the hospital. Specifically, the vendor technologist wrote:
 23 “I was told...there was no remote oversight, nor Medical Report for these cases, just
 24 the handwritten Event Log and Tech Billing Sheet. Again, there was no neurologist
 25 oversight.” (See Exhibit 5.)

26 74. On June 12, 2018, patient EH underwent ENT surgery at Keck Hospital.
 27 Dr. Gonzalez fraudulently claimed to have monitored the surgery remotely for two
 28 hours, and billed the insurer—Anthem Blue Cross—for two units of G0453.

1 75. On July 17, 2018, patient AK underwent ENT surgery at Keck Hospital.
 2 Dr. Gonzalez fraudulently claimed to have monitored the surgery remotely for three
 3 hours, and billed the insurer—Aetna Student Health—for three units of CPT code
 4 95941. Moreover, the medical record indicates that Dr. Gonzalez did not sign the
 5 IONM note despite billing for the case.

6 76. On June 12, 2018, patient RL underwent ENT surgery at Keck Hospital.
 7 Dr. Gonzalez fraudulently claimed to have monitored the surgery remotely for five
 8 hours, and billed the insurer—Anthem Blue Cross—for five units of CPT code 95941.

9 77. On April 27, 2018, patient GP underwent ENT surgery at Keck Hospital.
 10 Dr. Shilian fraudulently claimed to have monitored the surgery remotely for 1.75
 11 hours, and billed the insurer—Medicare—for seven units of G0453.

12 **iv. Falsification of provider name in order to maximize**
 13 **billing**

14 78. As described above, certain insurers, including Medicare, United
 15 Healthcare, Worker's Compensation carriers, and Senior HMO do not pay for the time
 16 spent monitoring more than one surgery at a time. Medi-Cal and certain commercial
 17 carriers do. Accordingly, if a physician was monitoring two surgeries at a time, and
 18 one of those surgeries was for a patient covered by Medicare, United Healthcare,
 19 Worker's Compensation, or Senior HMO, then USC simply falsified the record of one
 20 of the surgeries, switching the monitoring physician's name to another; typically a
 21 physician that was not scheduled to make clinical IOM decisions on that particular day
 22 at all.

23 79. The most straightforward evidence of this scheme are charges that Drs.
 24 Gonzalez and Shilian billed on days that they were not even available for IONM
 25 services. Per the division policy set by Dr. Chui, Dr. Gonzalez does not perform any
 26 IONM monitoring services on Mondays, which is considered his "academic day"—
 27 reserved for administrative and academic duties. Similarly, Dr. Shilian does not
 28 perform any IONM monitoring services on Thursdays; her "academic day."

1 80. Nonetheless, Drs. Gonzalez and Shilian fraudulently billed for hundreds
2 of IONM monitoring services on Mondays and Thursdays for the past several years.

3 81. For example, patient EN underwent surgery at Keck Hospital on February
4 12, 2018—a Monday. USC fraudulently billed the IONM monitoring services under
5 Dr. Gonzalez' name, when in fact he provided no monitoring. USC fraudulently billed
6 Medicare for 12 units of CPT code G0453 in addition to several base codes.

7 82. Patient LM, a 73 year-old Medicare patient, underwent surgery at Keck
8 Hospital on December 7, 2017—a Thursday. Despite not providing clinical IONM
9 care, Dr. Shilian fraudulently billed the patient's Medicare Advantage plan for 24 units
10 of CPT code G0453 in addition to several base codes.

11 83. Attached hereto as Exhibit 6 is an internal spreadsheet listing 107
12 examples of IONM monitoring services at USC Keck fraudulently billed by Drs.
13 Gonzalez and Shilian in 2017, for surgeries on dates on which they could not have
14 provided such services because they fell on their "academic days."

15 84. Dr. Shilian even billed for IONM services when she was out of the
16 country, on vacation in Italy (and even if she actually provided remote monitoring
17 services while on vacation, Medicare does not allow medical services to be provided
18 from outside of the United States). Specifically, patient DW underwent surgery at
19 Keck Hospital on August 15, 2017. Dr. Shilian was out of the country on that date.
20 Dr. Shilian nonetheless fraudulently billed Medicare for 33 units of CPT code G0453
21 in addition to several base codes. Notably, the Event Log for the surgery indicates that
22 there was a critical drop in IONM signals during the procedure, which the technologist
23 communicated to whichever physician was supposedly monitoring the surgery—
24 without documentation in the Event Log of any reply by the neurologist. (See Exhibit
25 10).

26 85. This switching of physician names was not a mistake. USC knowingly
27 and intentionally falsified the names of the performing physicians in order to maximize
28 reimbursement.

1 **v. Misrepresentations to L.A. County in connection with the**
 2 **MSOA and/or MSAA and/or PSA Contract**

3 86. In connection with the MSOA and/or MSAA and/or PSA contract with
 4 USC, Los Angeles County requires USC, twice yearly, to certify the time actually
 5 spent by USC's physicians for work at LAC+USC. These certifications are referred to
 6 as "Provider Time Studies" (PTS). In an internal e-mail, USC described the purposes
 7 of PTS as follows:

8 "All providers of these services are required to complete a Provider Time Study
 9 (PTS) survey twice a year in order to be in compliance with the county, state and
 10 federal government's cost reporting mandates; and to supply verification that the
 Keck School of Medicine is meeting its MSOA contractual service obligations."

11 (Exhibit 7.)

12 87. USC falsified the PTS for at least one of its IONM physicians,
 13 fraudulently reporting that 100% of that physician's time was dedicated to providing
 14 IONM monitoring services—or being "on call"—at LAC+USC. In fact, for the past
 15 several years, the IONM division policy set by Dr. Chui and memorialized in a
 16 schedule Dr. Chui distributed to the IONM physicians on June 29, 2018, strictly
 17 limited each IONM physician to certain days of the week on which they could make
 18 clinical decisions at both USC Keck and LAC+USC.

19 88. As indicated in USC's own internal documents, these PTS reports were
 20 material not only to USC's cost reporting mandates, but also verification of USC's
 21 compliance—or lack thereof—with its MSOA and/or MSAA and/or PSA contract with
 22 Los Angeles County.

23 **vi. Chat logs show lack of monitoring**

24 89. As described above, typewritten real-time chat logs serve as the bilateral
 25 communication channel between the operating room and the IONM physicians
 26 engaged in remote monitoring. The chat logs for surgeries monitored by USC
 27 physicians further evidence the failures to monitor described above, and also highlight
 28

1 additional problems with USC's IONM services which is the reason why Drs.
2 Gonzalez and Shilian ordered the chat logs deleted.

3 90. For example, patient RD, a 77 year-old Medicare patient, underwent
4 surgery at Keck Hospital on April 22, 2016. According to the Event Log, which is the
5 IONM technologist's real-time record of the surgery, the procedure commenced at
6 approximately 3:00 p.m. However, the first record in the Chat Log, which should
7 record all communications between the technologist and the monitoring physician, did
8 not occur until 4:48 p.m. That communication was from Dr. Gonzalez to the
9 technologist, and reads: "text me if any changes." This is a blatant admission by Dr.
10 Gonzalez that he was not continuously monitoring, and had no intention of doing so.
11 Instead, he left the monitoring responsibility to the technologist, a fundamental breach
12 of the standard of care. Worse still, one hour and twenty-two minutes later, the
13 technologist attempted to communicate a problem to Dr. Gonzalez via the Chat Log:
14 "Lt triceps & biceps 50% down from baseline." This is precisely the type of issue that
15 the monitoring physician is responsible for recognizing and interpreting, and for
16 communicating feedback or a recommendation to the operating surgeon. There was no
17 response from Dr. Gonzalez, however, and the surgery ended 45 minutes later.
18 Despite this utter failure to monitor the surgery, Dr. Gonzalez billed for two and a half
19 hours of monitoring (10 units of G0453) on top of multiple base codes.

20 91. Similarly, patient BG, a 71 year-old Medicare patient, underwent surgery
21 at Keck Hospital on August 4, 2015. The Chat Log reflects no communication
22 between the monitoring physician (Dr. Shilian) and the technologist until two and a
23 half hours into the surgery. The technologist writes: "dr. Shilian / are you there / are
24 you there?" There is no response from Dr. Shilian. As reflected in the Event Log, the
25 technologist was attempting to reach Dr. Shilian because there was a problem:
26 neurological signals in the left arm were down significantly from baseline. The
27 technologist never received a response from Dr. Shilian, and the technologist, nurse,
28 and surgeon were left on their own to troubleshoot.

92. Knowing that Chat Logs such as these lay bare the deficiencies of USC's IONM monitoring, Drs. Gonzalez and Shilian instructed IONM technologists and staff to simply delete all Chat Logs. Attached hereto as Exhibit 8 are Meeting Minutes from a June 27, 2018 Department meeting wherein staff were reminded to "Stop saving chat logs." The instruction was reiterated at a meeting on July 18, 2018, as reflecting in the Meeting Minutes. (Exhibit 9.) This bold destruction of evidence—and part of patients' medical records—is without excuse.

93. The schemes described above have led to fraud, waste, abuse, and thousands of violations of the False Claims Act, California False Claims Act, and California Insurance Fraud Protections Act. Defendant's schemes (1) caused the submission of false claims for reimbursement for both the professional and technical components of IONM services at USC Keck Hospital; (2) caused the submission of false claims for reimbursement for both the professional and technical components of IONM services at LAC+USC; (3) fraudulently induced Los Angeles County to enter into the MSOA and/or MSAA and/or PSA contracts under which USC was paid to provide services by IOM technologists and IOM physicians at LAC+USC; and (4) submitted false claims for payment to Los Angeles County under the MSOA and/or MSAA and/or PSA contracts.

V. CAUSES OF ACTION

FIRST CAUSE OF ACTION

ON BEHALF OF THE UNITED STATES VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT PRESENTING FALSE CLAIMS

(31 U.S.C. § 3729(a)(1)(A))

94. Relator incorporates herein by reference and realleges the allegations stated in this Complaint.

95. Defendant knowingly caused to be presented false claims for payment or approval to an officer or employee of the United States.

1 96. Defendant knowingly (as defined in 31 U.S.C. § 3729(b)(1)) presented
 2 false records and statements, including but not limited to claims, bills, invoices,
 3 requests for reimbursement, and records of services, in order to obtain payment or
 4 approval of charges by the Medicare and Medicaid program that were higher than they
 5 were permitted to claim or charge by applicable law for in-person monitoring
 6 physician services, among other things.

7 97. Defendant knowingly submitted false claims to Medicare with the
 8 incorrect monitoring physician's name in order to circumvent Medicare's limit of
 9 reimbursement for one surgery at a time, per monitoring physician.

10 98. Defendant knowingly made false claims and certifications that physicians
 11 remotely monitored surgeries, when in fact, only a technologist monitored.

12 99. Defendant knowingly made false certifications that physicians provided
 13 services during ENT surgeries.

14 100. Defendant knowingly made, used, and caused to be made and used false
 15 certifications that their claims, and all documents and data upon which those claims
 16 were based, were accurate, and were supplied in full compliance with all applicable
 17 statutes and regulations.

18 101. The conduct of Defendant violated 31 U.S.C. § 3729(a)(1)(A) and was a
 19 substantial factor in causing the United States to sustain damages in an amount
 20 according to proof.

21 **SECOND CAUSE OF ACTION**

22 **ON BEHALF OF THE UNITED STATES** 23 **VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT** 24 **MAKING OR USING FALSE RECORDS OR STATEMENTS** **MATERIAL TO PAYMENT OR APPROVAL OF FALSE CLAIMS**

25 **(31 U.S.C. § 3729(a)(1)(B))**

26 102. Relator incorporates herein by reference and realleges the allegations
 27 stated in this Complaint.

28 ///

103. Defendant knowingly (as defined in 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used false records or statements material to false or fraudulent claims.

104. Defendant knowingly made, used, and/or caused to be made and used false records and statements, including but not limited to claims, bills, invoices, requests for reimbursement, and records of services, in order to obtain payment or approval of charges by the Medicare program. Among other things, Defendant knowingly submitted false claims for Medicare and Medicaid business.

105. The conduct of Defendant violated 31 U.S.C. § 3729(a)(1)(B) and was a substantial factor in causing the United States to sustain damages in an amount according to proof.

THIRD CAUSE OF ACTION

ON BEHALF OF THE UNITED STATES VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT RETENTION OF PROCEEDS TO WHICH NOT ENTITLED

(31 U.S.C. 3729(A)(1)(G))

106. Relator incorporates herein by reference and realleges the allegations stated in this Complaint.

107. Defendant knowingly made, used, or caused to be made or used a false record or statement material to an obligation to pay or transmit money property to the United States, or knowingly concealed or knowingly improperly avoided or decreased an obligation to pay or transmit money or property to the United States.

108. Defendant received far more money from the Medicaid and Medicare programs than they were entitled. Defendant knew that they had received more money than they were entitled to, and avoided their obligation to return the excess money to the United States.

109. The conduct of Defendant violated 31 U.S.C. § 3729(a)(1)(G) and was a substantial factor in causing the United States to sustain damages in an amount according to proof.

FOURTH CAUSE OF ACTION

**ON BEHALF OF THE STATE OF CALIFORNIA
VIOLATIONS OF THE CALIFORNIA FALSE CLAIMS ACT
PRESENTING FALSE CLAIMS**

(Cal. Gov. Code § 12651, subd. (a)(1))

110. Relator incorporates herein by reference and realleges the allegations stated in this Complaint.

111. Defendant knowingly presented or caused to be presented false or fraudulent claims for payment or approval to an officer or employee of the State of California.

112. Defendant's false or fraudulent claims had the natural tendency to influence agency action or were capable of influencing agency action.

113. The State of California sustained damages because of Defendant's acts, in amounts to be proved at trial.

FIFTH CAUSE OF ACTION

**ON BEHALF OF THE STATE OF CALIFORNIA
VIOLATIONS OF THE CALIFORNIA FALSE CLAIMS ACT
MAKING OR USING FALSE RECORDS OR STATEMENTS TO OBTAIN
PAYMENT OR APPROVAL OF FALSE CLAIMS**

(Cal. Gov. Code § 12651, subd. (a)(2))

114. Relator incorporates herein by reference and realleges the allegations stated in this Complaint.

115. Defendant knowingly made, used, or caused to be made or used false records or statements to get false or fraudulent claims approved by the State of California, in violation of the California False Claims Act.

116. Defendant knowingly made, used, or caused to be made or used false records or statements material to false or fraudulent claims involving State funds, in violation of the California False Claims Act.

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1 117. Defendant's false records or statements had the natural tendency to
 2 influence, or capable of influencing, the payment or receipt of money, property, or
 3 services.

4 118. The State of California sustained damages because of Defendant's acts, in
 5 amounts to be proven at trial.

6 **SIXTH CAUSE OF ACTION**

7 **ON BEHALF OF THE STATE OF CALIFORNIA** 8 **VIOLATIONS OF THE CALIFORNIA FALSE CLAIMS ACT** 9 **INADVERTENT SUBMISSION OF FALSE CLAIMS**

10 **(Cal. Gov. Code § 12651, subd. (a)(8))**

11 119. Relator incorporates herein by reference and realleges the allegations
 12 stated in this Complaint.

13 120. Defendant was the beneficiary of inadvertent submissions of false claims,
 14 subsequently discovered the falsity of the claims, and failed to disclose the false claims
 15 to the State of California within a reasonable time after discovery of the false claims.

16 121. To the extent any of Defendant's complained of acts were inadvertent at
 17 the time committed, Defendant subsequently discovered they had engaged in
 18 fraudulent billing practices and failed to disclose the facts to the State of California
 19 within a reasonable time of such discovery.

20 122. Defendant's false or fraudulent claims had the natural tendency to
 21 influence agency action or were capable of influencing agency action.

22 123. The State of California sustained damages because of Defendant's acts, in
 23 amounts to be proved at trial.

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SEVENTH CAUSE OF ACTION

**ON BEHALF OF THE STATE OF CALIFORNIA
CALIFORNIA FRAUDS PREVENTION ACT
Cal. Ins. Code §1871.7 et seq. and Cal. Pen. Code § 550 et seq.
(Cal. Ins. Code 1871.7; Cal. Pen. Code 550(a)(5))**

124. Relator incorporates herein by reference and realleges the allegations stated in this Complaint.

125. This is a claim for treble damages and penalties under the California Insurance Frauds Prevention Act, Cal. Ins. Code § 1871.7 et seq., as amended (“the Act”). The Act provides for civil recoveries against persons who violate the provisions of the Act or the provisions of California Penal Code sections 549 or 550, including recovery of up to three times the amount of any fraudulent insurance claims, and fines of between \$5,000 and \$10,000 for each such claim. Cal. Ins. Code § 1871.7(b).

126. Subsection (e) of Cal. Ins. Code § 1871.7 provides for a qui tam civil action in order to create incentives for private individuals who are aware of fraud against insurers to help disclose and prosecute the fraud. Cal. Ins. Code § 1871.1(e).

127. Subsection (b) of Cal. Ins. Code § 1871.7 provides for civil recoveries against persons who violate the provisions of Penal Code sections 549 or 550. Section 550 of the Penal Code prohibits the following activities, among others:

(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

Cal. Penal Code § 550.

128. By virtue of the acts described in this Complaint, Defendant knowingly presented, or caused to be presented, false records and statements, including but not limited to bills, invoices, requests for reimbursement, and records of services, in order to obtain payment from insurers, in violation of Penal Code § 550(a) and Cal. Ins. Code § 1871.7(b). The claims were false or fraudulent because, among other things:

- Defendant knowingly sought, and falsely represented that it was entitled to reimbursement in excess of amounts it was owed;
- Defendant knowingly sought and falsely represented that it was entitled to reimbursement for services not actually performed;
- Defendant knowingly sought, and falsely represented that it was entitled to, reimbursement for treatment that did not meet the required conditions set out by insurers for reimbursement.

129. Defendant either directly presented such false claims for payment to insurers, or caused such false claims to be presented.

130. This conduct was a substantial factor in causing damages as detailed herein.

131. The California State Government is entitled to receive three times the amount of each claim for compensation submitted in violation of Cal. Ins. Code § 1871.7. Additionally, the California State Government is entitled to the maximum penalty of \$10,000 for each and every violation alleged herein.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff the United States of America, by and through Relator, prays for relief against Defendant as follows:

Pursuant to the False Claims Act:

TO THE UNITED STATES OF AMERICA AND QUI TAM PLAINTIFF:

1. For civil penalties of up to the maximum statutory amount to be imposed for each and every false and fraudulent claim for payment submitted, presented, or caused to be submitted to be presented to Medicare for payment;
2. For treble damages resulting to the Medicare system from the conduct of Defendant;
3. For pre- and post-judgment interest;
4. For reasonable attorneys' fees, costs, and expenses incurred in bringing this case; and
5. That Qui Tam Plaintiff be awarded the maximum percentage of recovery allowed to him pursuant to the False Claims Act.

Pursuant to the California False Claims Act:

TO THE PEOPLE OF CALIFORNIA AND QUI TAM PLAINTIFF:

6. For the maximum allowable civil penalties to be imposed for each and every false and fraudulent claim for payment submitted, presented, or caused to be submitted to presented to Medi-Cal for payment;
7. For treble damages resulting to the Medi-Cal system from the conduct of Defendant, and each of them;
8. For pre- and post-judgment interest;

1 9. For reasonable attorneys' fees, costs, and expenses incurred in bringing
2 this case; and

3 10. That Qui Tam Plaintiff be awarded the maximum percentage of any
4 recovery allowed to them pursuant to the California False Claims Act.

5 **Pursuant to the California Insurance Frauds Prevention Act:**

6 **TO THE PEOPLE OF CALIFORNIA AND QUI TAM PLAINTIFF:**

7 11. For the maximum allowable civil penalties to be imposed for each and
8 every false and fraudulent claim for payment submitted, presented, or
9 caused to be submitted or presented to an insurance company;

10 12. For an assessment of three times the amount of each claim for
11 compensation made by Defendant;

12 13. For pre- and post-judgment interest;

13 14. For reasonable attorneys' fees, costs, and expenses incurred in bringing
14 this case;

15 15. For an award of such other and further relief as this Court deems just and
16 proper; and

17 16. That the Qui Tam Plaintiff be awarded the maximum percentage of any
18 recovery allowed to him pursuant to Cal. Ins. Code § 1871.7.

19
20
21 Dated: September 26, 2018

COTCHETT, PITRE & McCARTHY, LLP

22
23 By: 

24 JUSTIN T. BERGER
SARVENAZ J. FAHIMI

25 *Attorneys for Relator*
26
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28

1 **VII. JURY DEMAND**

2 Plaintiffs demand a jury trial on all issues so triable.

3 Dated: September 26, 2018

COTCHETT, PITRE & McCARTHY, LLP

4
5
6 By: 

JUSTIN T. BERGER
SARVENAZ J. FAHIMI

7
8 *Attorneys for Relator*

EXHIBIT 1

Model Coverage Policy



Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing¹

BACKGROUND

Intraoperative neurophysiologic monitoring (IOM) and testing are medical procedures that have been in standard practice for almost 30 years. The procedures allow monitoring of neurophysiologic signals during a surgical procedure whenever the neuroaxis is at risk as a consequence of either the surgical manipulation or the surgical environment. IOM is an umbrella monitoring term and includes electroencephalography (EEG), cranial nerve evoked potentials (EPs), brain-stem auditory EPs (BAEPs), motor EPs (MEP), somatosensory EPs (SEP), nerve conduction, and electromyography (EMG) signals. Much like the other instrumental clinical monitoring technologies,

such as cardiac or capnic monitoring, randomized controlled trials establishing efficacy of IOM have not been done. Current best data, accumulated over the past two decades, have been derived through comparisons with historical controls and in the number of complications avoided through IOM. Difficulties in procedural blinding would impede accumulation of randomized controlled data. This status is not unlike that of intraoperative transesophageal echocardiography (TEE) or perioperative echocardiography (POE), two other widely-endorsed monitoring technologies (Memtsoudis et al., 2006, Ng 2009). Both neurophysiologic IOM and TEE/POE are recognized medical practice standards reliant on experience, case series and retrospective analyses.

IOM is of value in surgeries at diverse locations. The types of diseases for which monitoring is helpful also vary. For instance IOM may be necessary for carotid endarterectomies, removal of cortical-hemispheric lesions, extirpation of epileptic foci, brain stem surgeries, spinal corrections and peripheral nerve repairs to name some examples. IOM is used in neurosurgery, orthopedic, vascular, cardiothoracic and other surgical specialties. A compilation of recent reviews for these various areas is available (Nuwer, 2008). This policy addresses only surgical intraoperative monitoring and does not address monitoring performed in radiologic suites. The quality, extent and type of monitoring are dependent on the nature and location of the lesions. The utility of monitoring is exquisitely reliant on the rigors of the monitoring procedure and protocols, and the clinical expertise of the

monitoring physician. We list below several significant instances each of which has independently demonstrated the value of IOM in averting neural injuries during surgery.

¹ Approved by the AAN Board of Directors on February 10, 2012; replaces previous AANPA policy (2010-12).

1. Value of EEG Monitoring in Carotid Surgery

Carotid occlusion, incident to carotid endarterectomies, poses a high risk for cerebral hemispheric injury. EEG monitoring is capable of detecting cerebral ischemia, a serious prelude to injury. Studies of continuous monitoring established the ability of EEG to correctly predict risks of postoperative deficits after a deliberate, but necessary, carotid occlusion as part of the surgical procedure (Redekop & Ferguson, 1992; Cloughesy et al., 1993; Woodworth et al., 2007). The surgeon can respond to adverse EEG events by raising blood pressure, implanting a shunt, adjusting a poorly functioning shunt, or performing other interventions.

2. Multicenter Data in Spinal Surgeries

An extensive multicenter study conducted in 1995 demonstrated that IOM using SEP reduced the risk of paraplegia by 60% in spinal surgeries (Nuwer et al., 1995). The incidence of false negative cases, wherein an operative complication

occurred without having been detected by the monitoring procedure, was small: 0.06% (Nuwer et al., 1995).

3. Technology Assessment of Monitoring in Spinal Surgeries

A technology assessment by the McGill University Health Center (Erickson et al., 2005) reviewed 11 studies and concluded that spinal IOM is capable of substantially reducing injury in surgeries that pose a risk to spinal cord integrity. It recommended combined SEP/MEP monitoring, under the presence or constant availability of a monitoring physician, for all cases of spinal surgery for which there is a risk of spinal cord injury.

4. Value of Combined Motor and Sensory Monitoring

Numerous studies of post-surgical paraparesis and quadriparesis have shown that both SEP and MEP monitoring had predicted adverse outcomes in a timely fashion (Schwartz et al., 2007; Lee et al., 2006; Nuwer

Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing Model Coverage Policy



et al., 1995; Jones et al., 2003; Meyer et al., 1988; Pelosi et al., 2002; Hilibrand et al., 2004; Langeloo et al. 2003; Mostegl et al. 1988; Eggspuehler et al 2007; Leung et al. 2005; Khan et al., 2006; Sutter et al., 2007; Weinzierl et al., 2007). The timing of the predictions allowed the surgeons the opportunity to intervene and prevent adverse outcomes. The two different techniques (SEP and MEP) monitor different spinal cord tracts. Sometimes, one of the techniques cannot be used for practical purposes, for anesthetic reasons, or because of pre-operative absence of signals in those pathways. Thus, the decision about which of these techniques to use needs to be tailored to the individual patient's circumstances.

5. Protecting the Spinal Cord from Ischemia during Aortic Procedures

Studies have shown that IOM accurately predicts risks for spinal cord ischemia associated with clamping the aorta or ligating segmental spinal arteries (MacDonald & Janusz, 2002; Jacobs et al., 2000; Cunningham et al., 1987; Kaplan et al., 1986; Leung et al., 2005). IOM can assess whether the spinal cord is tolerating the degree of relative ischemia in these procedures. The surgeon can then respond by raising blood pressure, implanting a shunt, re-implanting segmental vessels, draining spinal fluid, or through other interventions.

6. Common Types of Alerting Events Observed During Monitoring

Another recent study (Lee et al., 2006) described types of neurophysiologic alerts and correlated them with postoperative neurological deficits that occurred during the course of 267 procedures involving anterior cervical spine surgery utilizing EMG, transcranial electrical motor and somatosensory evoked potential monitoring. In this study, 18.4 % of cases resulted in at least one intraoperative neurophysiologic alert; and major alerts believed to be

related to specific intraoperative surgical maneuvers were identified in 4.6% of the patients monitored. In 88% of the patients with relevant amplitude loss that was thought to be related to the surgical procedure, the signal response returned once appropriate intraoperative corrective measures were taken.

7. Value of EMG Monitoring

Selective posterior rhizotomy in cerebral palsy significantly reduces spasticity, increases range of motion, and improves functional skills (Staudt et al., 1995). Electromyography during this procedure can assist in selecting specific dorsal roots to transect. EMG can also be used in peripheral nerve procedures that pose a risk of injuries to nerves (Nuwer, 2008).

8. Futility of Monitoring Inappropriate Pathways

In order to be useful, monitoring should assess the appropriate sensory or motor pathways. Incorrect pathway monitoring could miss detection of neural compromise. Examples of "wrong pathway" monitoring have been shown to have resulted in adverse outcomes (Lesser et al., 1986).

9. Value of Spinal Monitoring using SSEP and MEPs

According to a recent review of spinal monitoring using SSEP and MEPs by the Therapeutics and Technology Assessment Subcommittee of the AAN and the American Clinical Neurophysiology Society, IOM is established as effective to predict an increased risk of the adverse outcomes of paraparesis, paraplegia, and quadriplegia in spinal surgery (4 Class I and 7 Class II studies) (Nuwer et al., 2012). Surgeons and other members of the operating team should be alerted to the increased risk of severe adverse neurologic outcomes in patients with important IOM changes (Level A).

NEUROPHYSIOLOGIC TECHNIQUES USED IN IOM

Several neurophysiologic testing modalities are useful during IOM. The location and type of surgery determine the chosen testing modality. The tests and codes listed here may be used individually or in combination.

- Electroencephalography (EEG);
 - With direct physician supervision, use codes 95822 plus 95940 and/or 95941
 - With general physician supervision, use code 95955
- Electrocorticography (ECoG);
 - Use code 95829
- Direct cortical stimulation to localize function;
 - Use codes 95961, 95962
- Deep brain stimulation electrode placement
 - Use codes 95961, 95962
- Pallidotomy site testing;
 - Use codes 95961, 95962
- Somatosensory evoked potential (SEP) monitoring
 - Use codes 95925, 95926, 95927, or 95938 plus 95940 and/or 95941

Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing Model Coverage Policy



- Intraoperative SEP identification of the sensorimotor cortex
 - Use codes 95961, 95962
- Motor evoked potentials (MEP)
 - Use codes 95928, 95929, or 95939 plus 95940 and/or 95941
- Mapping the descending corticospinal tract
 - Use codes 95928, 95929, or 95939 plus 95940 and/or 95941
- Brainstem auditory evoked potentials
 - Use code 92585 plus 95940 and/or 95941
- Peripheral nerve stimulation and recording
 - Use one code from among codes 95907-95913, plus 95940 and/or 95941
- Oculomotor, facial, trigeminal and lower cranial nerve monitoring
 - Use codes 95867, 95868 and/or 95933 plus 95940 and/or 95941
- EMG monitoring and testing of peripheral limb pathways
 - Use codes 95861, 95862 or 95870 plus 95940 and/or 95941
- Pedicle screw stimulation
 - Use codes 95861, 95862 or 95870 plus 95940 and/or 95941
- Selective dorsal rhizotomy rootlet testing;
 - Use codes 95861, 95862 or 95870 plus 95940 and/or 95941
- Transcranial electrical MEPs (tceMEPs) for external anal and urethral sphincter muscles monitoring.
 - Use code 95870 plus 95940 and/or 95941

LIMITATIONS ON COVERAGE

To derive optimal benefits from this technology it is incumbent on the IOM team to understand the limits of the technology, listed below.

1. Use of Qualified Personnel

IOM must be furnished by qualified personnel. For instance, the beneficial results of monitoring with SSEPs demonstrated by the 1995 multicenter study (Nuwer et al., 1995) showed fewer neurological deficits with experienced monitoring teams. While false positive events were significant in only 1% of cases, the negative predictive value for this technique was over 99%. Thus, absence of events during monitoring signifies and assures safety of the procedure. In general it is recommended that the monitoring team strive to optimize recording and interpreting conditions such that:

- A well-trained, experienced technologist, present at the operating site, is recording and monitoring a single surgical case; and
- A monitoring clinical neurophysiologist supervises the technologist.

2. Effects of the Depth of Anesthesia and Muscle Relaxation

The level of anesthesia may also significantly impact on the ability to interpret intraoperative studies; therefore, pre-operative planning and continuous communication between the anesthesiologist and the monitoring team is expected.

3. Recording Conditions

It is also expected that a specifically trained technologist or non-physician monitorist, preferably with credentials from the American Board of Neurophysiologic Monitoring or the American Board of Registration of Electrodiagnostic

Technologists (ABRET), will be in continuous attendance in the operating room, with either the physical or electronic capability for real-time communication with the supervising physician.

4. Monitoring Necessity

Intraoperative monitoring is not medically necessary in situations where historical data and current practices reveal no potential for damage to neural integrity during surgery. Monitoring under these circumstances will exceed the patient's medical need (Social Security Act (Title XVIII); Medicare Benefit Policy Manual).

5. Communications

Monitoring may be performed from a remote site, as long as a well-trained technologist (see detail above) is in continuous attendance in the operating room, with either the physical or electronic ability for prompt real-time communication with the supervising monitoring physician.

6. Supervision Requirements

Different levels of physician supervision apply to different kinds of IOM procedures. Code 95940 supervision require continuous physician monitoring in the operating room (OR). Code 95941 supervision require continuous physician monitoring which can be provided online or in the operating room (OR). Codes 95961-95962 (Functional cortical localization with brain stimulation) require personal physician supervision in the OR.

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USE OF CODES 95940, 95941 AND THEIR BASE PROCEDURE CODES

1. IOM is a procedure that describes ongoing electrophysiologic testing, and monitoring performed during surgical procedures. It includes only the time spent during an ongoing, concurrent, real-time electrophysiologic monitoring.
2. Time spent in clinical activities, other than those above, should not be billed under 95940 and/or 95941. The time spent performing or interpreting the baseline electrophysiologic studies must not be counted as intraoperative monitoring, but represents separately reportable procedures.

For example, 95940 and 95941 are distinct from performance of specific types of pre-procedural baseline electrophysiologic studies (95860, 95861, 95867, 95868, 95907-95913, 95933, 95937) or other interpretation of specific types of baseline electrophysiologic studies (95985, 95922, 95925-95930, 95938, 95939).

The supervising physician time spent in the operating room includes the time from entering until leaving the operating room, except for the time spent interpreting the baseline testing. For remote monitoring, it includes time from initiating to discontinuing monitoring except for the time spent interpreting the baseline testing.

3. Note that the supervision requirements for each underlying test or primary test modality vary, and must be met (Medicare Benefit Policy Manual). For example, cortical mapping during monitoring requires personal supervision.
4. Codes 95940 and 95941 may not be reported by the surgeon or anesthesiologist performing an operative

procedure, since it is included in the global package if they serve as the IOM supervising physician.. The surgeon performing an operative procedure may not bill other 90000 series neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95939) since they are also included in the global package (Medicare Benefit Policy Manual). However, when IOM or baseline procedures are performed by a different, monitoring physician during the procedure, it is separately reportable by the monitoring supervising physician.

5. Codes 95940 and 95941 is performed in the hospital setting. Monitoring of a patient with codes 95940 and 95941 should use hospital site of service (site 21), or hospital outpatient surgery center (site 22), even if the monitoring physician is located in an office. When supervising and interpreting IOM on a hospitalized patient, the supervising physician codes uses modifier -26.
6. Code 95940 requires one-on-one monitoring. Simultaneous cases cannot be coded with 95940. Code 94941 allows for reporting simultaneous cases without division of time between them. The number of cases monitored at any one time will vary, but should not exceed the requirements for providing adequate attention to each. For example, a 2010 AAN survey of IOM practitioners shows that on average 90% of monitoring hours are spent monitoring three (3) or fewer simultaneous cases and that practitioners rarely monitor more than six (6) cases simultaneously (2010 AAN Survey of IOM Practitioners – unpublished).

CPT/HCPCS CODES

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Codes 95940, 95941 describe ongoing neurophysiologic monitoring, testing, and data interpretation distinct from performance of specific type(s) of baseline neurophysiologic study(s) performed during surgical procedures. When the service is performed by the surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologists's primary

services code(s) for the procedure and are not reported separately. Do not report these codes for automated monitoring devices that do not require continuous attendance by a professional qualified to interpret the testing and monitoring.

Recording and testing are performed either personally or by a technologist who is physically present with the patient during the service. Supervision is performed either in the operating room or by real time connection outside the operating room. The monitoring professional must be solely dedicated to performing the intraoperative neurophysiologic monitoring

Principles of Coding for Intraoperative Neurophysiologic Monitoring (IOM) and Testing Model Coverage Policy



and must be available to intervene at all times during the service as necessary, for the reported time period(s). For any given period of time spent providing these services, the service takes full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time.

Throughout the monitoring, there must be provisions for continuous and immediate communication directly with the operating room team in the surgical suite. One or more simultaneous cases may be reported (95941). When monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual's exclusive attention be required for another procedure. Report 95941 for all remote or non-one-on-one monitoring time connected to each case regardless of overlap with other cases.

Codes 95940, 95941 include only the ongoing neurophysiologic monitoring time distinct from performance of specific type(s) of baseline neurophysiologic study(s), or other services such as intraoperative functional cortical or subcortical mapping. Codes 95940 and 95941 are reported based upon the time spent monitoring only, and not the number of baseline tests performed or parameters monitored. The time spent performing or interpreting the baseline neurophysiologic study(ies) should not be counted as intraoperative monitoring, but represents separately reportable procedures. When reporting 95940 and 95941, the same neurophysiologic study(ies) performed at baseline should be reported not more than once per operative session. Baseline study reporting is based upon the total unique studies performed. For example, if during the course of baseline testing and one-on-one monitoring, two separate nerves have motor testing performed in conjunction with limited single extremity EMG, then 95885 and 95907 would be reported in addition to 95940. For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total time monitored.

Code 95940 is reported per 15 minutes of service. Code 95940 requires reporting only the portion of time the monitoring professional was physically present in the operating room providing one-on-one patient monitoring and no other cases may be monitored at the same time. Report continuous intraoperative neurophysiologic monitoring in the operating room (95940) in addition to the services related to monitoring from outside the operating room (95941).

Code 95941 should be used once per hour even if multiple methods of neurophysiologic monitoring are used during the time. Code 95941 requires the monitoring of neurophysiological data that is collected from the operating room continuously on-line in real time via a secure data link. When reporting 95941, real-time ability must be available through sufficient data bandwidth transfer rates to view and interrogate the neurophysiologic data contemporaneously.

Report 95941 for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time or when monitoring more than one case in an operating room. It is also used to report the time of monitoring physically performed outside of the operating room in those cases where monitoring occurred both within and outside the operating room. Do not report 95941 if the monitoring lasted 30 minutes or less.

Intraoperative neurophysiology monitoring codes 95940 and 95941 are each used to report the total duration of respective time spent providing each services, even if that time is not in a single continuous block.

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)

95941 Continuous intraoperative neurophysiologic monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)

(Use 95940 & 95941 in conjunction with the study performed, 92585, 95822, 95860-95870, 95907-95913, 95925-95939)

(For time spent waiting on standby before monitoring, use 99360) (For electrocorticography, use 95829)

(For intraoperative EEG during nonintracranial surgery, use 95955)

(For intraoperative functional cortical or subcortical mapping, see 95961- 95962)

(For intraoperative neurostimulator programming and analysis, see 95970- 95979)